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Billing and Policy
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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. Specific policy changes are detailed below.

ANESTHESIA

New CPT-4 codes 01965 and 01966 (anesthesia for abortions) replace code 01964. These codes may be billed as regional or general, or both. Claims must include start and stop times.

SURGERY

No more than three of any combination of new CPT-4 codes 22523 – 22525 (percutaneous vertebroplasty) may be billed on the same date of service. In addition, these codes are not separately reimbursable when performed at the same vertebral level as code 20225 (deep bone biopsy) on the same date of service. If these procedures are billed for the same date of service, the vertebral levels for each code must be specified on the claim.

CPT-4 code 33886 (placement of distal extension prosthesis) may be reimbursed only once per day, any provider.

CPT-4 codes 33925 and 33926 (repair of pulmonary artery) are reimbursable for a second assistant surgeon.

Reimbursement for more than three vessels for CPT-4 code 37185 (arterial mechanical thrombectomy, subsequent vessels) on a single date of service requires medical justification, which must be documented in the *Remarks* area of the claim.

CPT-4 codes 45395 and 45397 (removal of rectum) and HCPCS code S2078 (hysterectomy) are once-in-a-lifetime procedures. S2078 requires the completion of a *Hysterectomy Consent* form.

CPT-4 codes 43848 (revision of gastric restrictive procedure) and 53850 (transurethral destruction of prostate tissue) have been added as Medi-Cal benefits. Both procedures require prior authorization.

HCPCS code E0616 (implantable cardiac event recorder) is a Medi-Cal benefit, subject to prior authorization. Claims will be reimbursed at invoice cost.

HCPCS codes for bio-engineered skin substitutes J7340 (Apligraf), J7342 (Dermagraft) and J7343 (Integra) will be Medi-Cal benefits. These codes require a *Treatment Authorization Request* (TAR) and documentation of medical necessity. Claims must be billed with an appropriate primary surgery code, ICD-9 diagnosis code and, if necessary, an add-on surgery code.

Please see **CPT-4/HCPCS**, *page 2*

HCPCS codes L8623 and L8624 (lithium batteries for cochlear implants) are Medi-Cal benefits, subject to prior authorization. These items will be reimbursed at 80 percent of the 2006 Medicare rate.

HCPCS codes L8680 – L8683 and L8685 – L8689 (neurostimulator device and accessories) require prior authorization, and are separately reimbursable only when specifically excluded from a hospital's negotiated contract. Reimbursement will be at invoice cost.

Claims for codes Q0480 – Q0505 (ventricular assist devices and accessories) will be reimbursed at invoice cost.

HCPCS code S2117 (subtalar arthroereisis) is reimbursable to podiatrists.

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code(s)
15342	15170, 15175, 15340, 15360, 15365
15343	15171, 15176, 15341, 15361, 15366
15350	15300, 15320, 15330, 15335
15351	15301, 15321, 15331, 15336
44200	44180
44201	44186
44239	45499
C9718	22523
C9719	22525
E0752	L8680
E0754	L8681
E0756	L8685 – L8688
E0757 – E0759	L8682 – L8683
K0731	L8623
K0732	L8624

RADIOLOGY

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code(s)
78990	A4641
79900	A9699
A4643, A4647	Q9952 – Q9954
A4644	Q9945 – Q9946
X7660	A9543
X7662	A9542

Billing Restrictions: Radiology Procedures
CPT code 75958 (placement of proximal distal extension prosthesis, radiological supervision and interpretation) requires medical justification when more than three procedures are billed for the same date of service.

Reimbursement for CPT-4 code 75959 (placement of distal extension prosthesis, radiological supervision and interpretation) is limited to once per date of service, regardless of the number of modules deployed.

CPT-4 codes 75956 – 75959, 76376, 76377, 77422 and 77423 are split-billable and must be billed with the appropriate modifier (-26, -99, -TC or -ZS).

CPT-4 code 77421 (stereoscopic X-ray guidance) must be billed with modifier -26.

Please see **CPT-4/HCPCS**, *page 3*

Billing Restrictions: **Contrast Materials and Media**
All radiopharmaceutical supply HCPCS codes must be billed with modifier -ZS.

Claims for the following HCPCS codes (radiopharmaceutical contrast material) must include documentation to justify billing for more than one unit: A4642, A9500, A9502 – A9504, A9507, A9510, A9512, A9521, A9526, A9536 – A9543, A9546, A9549 – A9555, A9557, A9559 – A9562, A9566 and A9567.

Code A9552 (Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose) will be reimbursed only if a PET scan code is billed on the same date of service.

Only one of HCPCS codes Q9945 – Q9957 (non-ionic radiographic contrast media) may be billed per day. Code Q9951 (400 or greater mg/ml) must be billed "By Report."

PATHOLOGY

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes

Deleted Code(s)	Replacement Code(s)
82273	82271
83715, 83716	83700, 83701
86379	86357
86587	86367

Billing Restrictions
The following codes are split-billable and must be billed with the appropriate modifiers (-26, -99, -TC or -ZS): 80195, 82271, 82272, 83631, 83695, 83700, 83701, 83704, 83900, 83907 – 83909, 83914, 86200, 86355, 86357, 86367, 86480, 86923, 86960, 87209, 87900, 88333, 88334 and 89049.

CPT-4 code 86480 (QuantiFERON-TB Gold test) is reimbursable for patients 17 years of age or older for the diagnosis of latent tuberculosis infection and tuberculosis disease. This test is not approved for patients with the following medical conditions:

- Infected with human immunodeficiency virus (HIV)
- Receiving immunosuppressive drugs including prolonged or high-dose corticosteroids, tumor necrosis factor-alpha antagonists and drugs used for managing organ transplantation
- Selected hematologic disorders (for example, myeloproliferative disorders, leukemia and lymphomas)
- Specific malignancies (for example, carcinoma of the head, neck or lung)
- Diabetes
- Silicosis, or
- Chronic renal failure

CPT-4 code 86849 (unlisted immunology procedure) may no longer be used to bill for the QuantiFERON-TB test.

CPT-4 code 89049 (CHCT for malignant hypertension) is reimbursable only to the University of California, Los Angeles.

Please see **CPT-4/HCPCS**, *page 4*

MEDICINE

Deleted and Replacement Codes

The following are deleted CPT-4 codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code(s)	Replacement Code(s)
90780, 90781	90760, 90761, 90765 – 90768
90799	90779
96100	96101
96115	96116
96117	96118
96400	96401, 96402
96408	96409
96410	96413
96412	96415
96414	96416
96520	96521
96530	96522
99301 – 99303	99304 – 99306
99311 – 99313	99307 – 99309
99321 – 99323	99234 – 99236
99331 – 99333	99334 – 99336

Billing Restrictions

Codes 58110, 82271, 92626, 92627, 92630, 92633, 96101, 96116, 96118, 96521 and 96522 are classified as common office procedures. Reimbursement for these codes will be cut back to 80 percent of the reimbursement amount when performed in an emergency room or outpatient hospital setting.

Claims for CPT-4 codes 90760 (hydration, first hour) and 90765 (IV infusion, first hour) must include documentation that the physician personally administered or directly supervised the infusion therapy.

Claims for CPT-4 codes 90761 (hydration, each additional hour) and 90766 (IV infusion, each additional hour) must include medical justification when billed for more than one additional hour. The maximum allowed is eight additional hours.

Claims for CPT-4 codes 90767 and 90768 must include documentation to justify the need for concurrent or sequential infusion.

Reimbursement for any combination of codes 95860 – 95875 (electromyography) is limited to four times per year. Medical justification for additional services must be documented in the *Remarks* area of the claim. These services are reimbursable only to providers who have a diploma or certificate of completion of an accredited neurology or physical medicine and rehabilitation residency program.

Claims for CPT-4 codes 96101 (psychological testing), 96116 and 96118 (neuropsychological testing) must include a report that documents the results of the specific assessments and/or tests.

Claims for code 96415 (chemotherapy IV infusion, each additional hour) require medical justification if billed for more than one hour. The maximum additional hours allowed is eight.

Codes 99143, 99144, 99148 and 99149 (conscious sedation) are exempt from the 50 percent multiple surgery cutback when billed with modifier -51.

Codes 99145 and 99150 (conscious sedation) require medical justification if billed for more than two units (30 minutes).

CPT-4 codes 99304, 99307 – 99309, 99324 – 99326 and 99334 – 99336 are reimbursable to podiatrists.

Please see **CPT-4/HCPCS**, *page 5*

Add-On Codes

The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding code for the primary procedure:

Add-On Code	Primary Procedure Code(s)
15111	15110
15116	15115
15131	15130
15136	15135
15151 *	15150
15152	15151
15156 *	15155
15157	15156
15171	15170
15176	15175
15301	15300
15321	15320
15331	15330
15336	15335
15341	15340
15361	15360
15366	15365
15421	15420
15431	15430
22525	22523, 22524
31620	31622 – 31646
33768	33478, 33617, 33767
33884	33883
33924	33470 – 33475, 33600 – 33619, 33684 – 33688, 33692 – 33697, 33735 – 33767, 33770 – 33781, 33786, 33920 – 33922
44213	44204 – 44208
58110	57420, 57421, 57454 – 57461
61641, 61642	61640
83901	83900
90761	90760
90766	90765, 90767
90767	90765, 90774, 96409, 96413 **
90768	90765, 96413
92627	92626
93662	92987, 93527, 93532, 93580, 93581, 93621, 93622, 93651, 93652
95873, 95874	64612 – 64614
96411	96409, 96413
96415, 96417	96413
99145	99143, 99144
99150	99148, 99149
99356	99221 – 99233, 99251 – 99255

All of the add-on codes listed above are exempt from the multiple surgery cutback when billed with modifier -51.

* Reimbursement for codes 15151 and 15156 are limited to once per session, same provider. Claims for more than once per day must include a statement in the *Remarks* area that the procedure was not performed during the same session.

** When performed as a secondary or subsequent service.

Please see **CPT-4/HCPCS**, *page 6*

DRUGS, INJECTIONS

New HCPCS Codes
The following HCPCS codes may be billed up to the amounts specified below:

Code	Description	Maximum Units
J0133	Acyclovir, 5 mg	300 units
J1451	Fomepizole, 15 mg	140 units
J2425	Palifermin, 50 mcg	140 units

Deleted and Replacement Codes
The following are deleted codes and their replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted Code	Replacement Code(s)
Q0187	J7189
Q2022	J7188
Q4077	J3285
X1520	J7306
X6112	J1265
X6210	J1752
X6836	J0886
X7030	J0885
X7493	J0881 – J0882

Billing Restrictions
Claims for injection code A9535 (methylene blue) must include documentation to justify medical necessity when billed in excess of 20 ml.

HCPCS code C9225 (fluocinolone acetonide intravitreal implant [Retisert]) is reimbursable for patients with chronic non-infectious uveitis affecting the posterior segment of the eye. Claims require prior authorization.

Codes J0480 (basiliximab), J0795 (corticorelin ovine triflutate) and J1675 (histrelin acetate) require prior authorization.

Injection code J0795 (corticorelin ovine triflutate) is reimbursable, with prior authorization, for patients with Cushing's Syndrome. ICD-9 diagnosis code 255.0 must be included on the TAR.

Injection codes J0881 – J0882 (darbepoetin) and J0885 – J0886 (epoetin) must be billed with one of the following ICD-9 diagnosis codes:

- J0881: 140.0 – 239.9 or a combination of V58.11 or V58.12 and 285.22 or 285.29
- J0882: 585.1 – 585.9, 586 or a combination of V56.0 – V56.8 and 285.21
- J0886: 585.6 or 285.21

Note: J0885 (epoetin, non-ESRD [end stage renal disease]) cannot be billed with ICD-9 code 585.6.

Injection code J1640 (hemin, 1 mg) may be reimbursed up to a maximum of 602 mg and is limited to females 10 years of age or older.

Injection code J2503 (pegaptanib) is reimbursable, with prior authorization, for patients with macular degeneration.

Claims for injection code J2504 (pegademase bovine) must be billed with ICD-9 diagnosis code 277.2 or 279.2.

Injection code J2850 (secretin, synthetic) is reimbursable, with prior authorization, for patients with Islets of Langerhans (ICD-9 code 157.4). The maximum dosage allowed is 48 mcg.

Please see **CPT-4/HCPCS**, *page 7*

Injection code J3285 (treproprostinil, 1 mg) is reimbursable, with prior authorization, for patients 16 years of age or older who have pulmonary heart disease.

Injection code J7306 (levonorgestrel implant system) is reimbursable for females 12 to 55 years of age. Claims require either a copy of the invoice or documentation of the invoice number and price in the *Remarks* area of the claim form. Reimbursement is limited to once in three years. Providers billing for J7306 more than once in three years must document on the claim the necessity for the repeat implant.

Injection code J9225 (histrelin implant, 50 mg) is reimbursable only for males 30 years of age or older.

Injection code J9264 (paclitaxel protein-bound particles, 1 mg) may be reimbursed up to a maximum of 500 mg and must be billed with ICD-9 codes 174.0 – 175.9.

Injection code Q0515 (sermorelin acetate) requires a TAR. ICD-9 codes 253.0 – 253.9 must be included on the TAR.

Injection code Q4079 (natalizumab, 1 mg) must be billed with ICD-9 diagnosis code 340. Reimbursement is allowed up to a maximum of 300 mg.

The manual replacement pages reflecting these policies will be released in the October *Medi-Cal Update.*

Genetic Testing and Counseling – HIPAA Code Conversions

Effective for dates of service on or after November 1, 2006, six Medi-Cal interim billing codes for genetic testing and counseling services will be end-dated and converted to HCPCS Level II codes in order to comply with the Federal Health Insurance Portability and Accountability Act (HIPAA). The codes and their conversions are below:

End-dated Interim Code	HCPCS Level II Code
Z2500 (Newborn Screening Test)	S3620 (Newborn Metabolic Screening Panel)
Z2502 (Maternal Alpha-Fetoprotein Screening)	Code no longer used
Z2503 (Expanded AFP [X-AFP])	S3625 (Maternal Serum Multiple Marker [MSMM] screen, including Alpha-Fetoprotein, estriol and human Chorionic Gonadotropin)
Z0002, Z0004, Z0006 (Genetic counseling)	S0265 (Genetic counseling, under physician supervision, each 15 minutes)

All existing policies for code Z2500 will be transferred to code S3620. Code S3620 may only be billed for services provided to newborns. Claims must be billed with modifier -90.

All existing policies for code Z2503 will be transferred to code S3625, with the exception that code S3625 is now split-billable and must be billed with the appropriate modifiers (-TC, -ZS, -26, -99).

Genetic counseling services billed with code S0265 are now limited to four claims per recipient per year. Maximum reimbursement for code S0265 is $15 per each unit of 15 minutes spent with each recipient. The maximum number of units that may be billed per day is eight (two hours).

Additional units beyond the maximum allowance of eight must be justified with a Medical Consultation note. Additional units will be reimbursed at a rate of $5 per unit per day and may not exceed 16 additional units, or four additional hours, spent with the recipient for genetic counseling.

Providers must indicate the number of 15-minute units spent with a recipient in the *Service Units* field (Box 46) of the *UB-92 Claim Form* for code S0265. Failure to indicate the number of units spent will result in a reimbursement of $15 only.

Please see **Genetic Testing**, *page 8*

Address and Phone Number Updates
The address for ordering literature in connection with genetic screening is updated as follows:

California Expanded AFP Screening Program
Genetic Disease Branch
California Department of Health Services
850 Marine Bay Parkway, F175
Richmond, CA 94804
(510) 412-1441
Fax: (510) 412-1553

The address for obtaining newborn screening forms and collection cards and to receive screening laboratory assignments or laboratory provider numbers is updated as follows:

Newborn Screening Section
Genetic Disease Branch
California Department of Health Services
850 Marine Bay Parkway, F-175
Mail Stop 8200
Richmond, CA 94804
(510) 412-1542
FAX: (510) 412-1559

The manual replacement pages reflecting this policy will be released in the October *Medi-Cal Update.*

Respiratory Syncytial Virus (RSV) Update 2006

The California Department of Health Services (CDHS) and MedImmune, Inc. invites providers to participate in a live interactive webcast at **www.livemeeting.com/cc/medimmune/join**. The event features presentations by:

- Vincent A. Haynes, M.D., FAAP – Director, Medical Sciences for MedImmune, Inc., and Clinical Associate and Professor of Pediatrics at USC School of Medicine.
- Barry Handon, M.D. – Medical Consultant for Medi-Cal Policy Division for CDHS
- Kathy Chance, M.D. – Medical Consultant for Children's Medical Services for CDHS

Objectives

- Discuss the epidemiology of Respiratory Syncytial Virus (RSV)
- Define the risk factors for severe lower respiratory disease caused by RSV
- Identify RSV prevention strategies
- Discuss recent Medi-Cal policy changes for Synagis (palivizumab)

When

The same webcast will be offered on the following two dates and times:

Monday	***Tuesday***
September 25, 2006	**September 26, 2006**
12 – 1:30 p.m.	12 – 1:30 p.m.

Please see **RSV Update**, *page 9*

The only requirement necessary to join the webcast is a telephone near a computer with an Internet connection. To listen to the audio portion, call 1-866-897-4137 and enter participant code **9259730261**. To view the webcast, log on to the Web site at **www.livemeeting.com/cc/medimmune/join** and enter the following information:

- Your name
- The following Meeting ID number: CJ8M69
- Leave the Meeting Key field blank

Webcast viewers should log on to **go.microsoft.com/fwlink/?linkid=52354** prior to the day of the webcast (but no later than 15 minutes before the webcast) to make sure their system is compatible with Microsoft Office Live Meeting. For technical support with the webcast, please call 1-800-374-1852.

Coronary Bypass Surgeries Reimbursable at Full Rate

Surgical add-on procedures billed with CPT-4 codes 33518, 33519 and 33521 are reimbursable at the full rate (without the multiple surgery reduction) when billed with modifier -51. These codes were inadvertently removed from the "Surgical Procedures Exempt from Reimbursement Cutback" table in the provider manual, but have been added back.

Policy has always been in effect for these codes. Providers do not need to resubmit claims for these codes.

These additions are reflected on manual replacement page surg bil mod 7 (Part 2).

TAR Requirement Lifted for Podiatrists for Selected Surgery Services

In compliance with *Welfare and Institutions Code* (W&I Code), Section 14133.07, effective for dates of service on or after October 1, 2006, podiatrists are no longer required to obtain a *Treatment Authorization Request* (TAR) for the surgery services identified below. Podiatrists are required to submit the following documentation or operative report when billing for the identified services.

CPT-4 Codes	Surgery Service	Documentation Required
10060, 10160, 10180	Incision and drainage	Infection present and local anesthesia injected
11730, 11732	Nails	Infection present and local anesthesia injected
27650 – 27654, 27658 – 27698, 27704	Leg (tibia and fibula) and ankle joint: repair, revision and/or reconstruction	Date of injury and date of treatment (must be within one month of injury)
27760 – 27766, 27786 – 27829, 27840 – 27848	Leg (tibia and fibula) and ankle joint: fracture and/or dislocation	Date of injury and date of treatment (must be within one month of injury)
28415, 28430 – 28515	Foot and toes: fracture and/or dislocation	Date of injury and date of treatment (must be within one month of injury)
28190	Foot and toes: introduction or removal	Local anesthesia injected
28192, 28193	Foot and toes: introduction or removal	Operative report justifying level of code billed

The updated information is reflected on manual replacement pages podi 1 and 2 (Part 2).

RHC and FQHC Rate Changes

Effective October 1, 2006, the Medicare Economic Index (MEI) percentage increase is 2.8 percent for any Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) with an established Prospective Payment System (PPS) rate. Per federal requirements, any FQHC or RHC that has an established PPS rate must have it adjusted according to the MEI.

OB 'Time in Attendance' Clarification

When billing for obstetrical regional anesthesia (CPT-4 code 01967), in addition to documenting anesthesia start and stop times, providers also must document "time in attendance" in the *Remarks* area of the claim. Claims without such documentation will be denied. Only time in attendance with the patient may be billed.

"Time in attendance" is time where the anesthesiologist or certified registered nurse anesthetist (CRNA) is monitoring the patient receiving neuraxial labor analgesia, and the anesthesiologist or CRNA is readily and immediately available in the labor or delivery suite. If the actual time in attendance is less than the total quantity billed (in the *Service Units* field [Box 46]), the claim will be reimbursed according to the time in attendance with the patient. If two or more patients are receiving neuraxial analgesia concurrently, no more than four total time units per hour may be billed and must be apportioned among the claims, including claims to other insurance carriers. For billing examples, see "Time in Attendance With the Patient" in the *Anesthesia* section in the Part 2 manual.

This information is reflected on manual replacement pages anest 2 thru 4 (Part 2).

Revised Reporting for Pap Smear Tests

In accordance with the 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4 code book), the provider manual has been updated to reflect changes in reporting for codes used to bill for Pap smear tests. The policy for these codes remains unchanged. *The updated information is reflected on manual replacement page path cyto 1 (Part 2).*

Transvaginal Ultrasound Billing Clarification

Effective for dates of service on or after October 1, 2006, CPT-4 code 76830 (ultrasound, transvaginal) is not reimbursable when billed in conjunction with the following obstetric diagnosis codes: 630 – 633.99, 640.00 – 663.93, V22.0 – V23.7, V23.81 – V23.89, V23.9, V28.0 – V28.9 and V61.5 – V61.7. Code 76830 is billed for non-obstetrical ultrasounds and these ICD-9 codes represent obstetric diagnoses.

The updated information is reflected on manual replacement pages preg early 8 (Part 2) and radi dia ult 1 (Part 2).

Payment Reduction Reversed for Select Genetic Disease Lab Panels

The 5 percent payment reduction that was applied to the following genetic disease tests for dates of service on January 1, 2006 through March 3, 2006 is being reversed. These procedures are considered laboratory services and, therefore, should have been exempt from the reduction.

HCPCS Code	Description
Z2500	Newborn screening panel for phenylketonuria (PKU), galactosemia, primary congenital hypothyroidism or hemoglobinopathies
Z2502	Alpha Fetal Protein (AFP) screening panel
Z2503	Expanded Alpha-Fetal Protein (X-AFP) screening panel

Providers need take no action. Claims for these codes for the affected dates of service will be reprocessed for correct payment.

Arterial Blood Gas Tests Billing Update and Reminder

Effective for dates of service on or after October 1, 2006, physicians and physician groups may no longer bill for the technical and/or professional component(s) of the following arterial blood gas analyses, using their physician or physician group provider number:

CPT-4 Code	Description
82800	Gases, blood, pH only
82803	Gases, blood, any combination of pH, pCO_2, pO_2, CO_2, HCO_2 (including calculated O_2 saturation)
82805	with O_2 saturation, by direct measurement, except pulse oximetry
82810	Gases, blood, O_2 saturation only, by direct measurement, except pulse oximetry
82820	Hemoglobin-oxygen affinity (pO_2 for 50% hemoglobin saturation with oxygen)

Physicians and physician groups may bill only for clinical laboratory tests or examinations classified as waived or Provider-Performed Microscopy Procedures (PPMP) using their physician or physician group provider number.

Physicians and physician groups specializing in pulmonary diseases may bill for the professional component (physician review with interpretation and report) of blood gas testing (using modifier -26), only under the auspices of a hospital's Clinical Laboratory Improvement Amendment (CLIA) certificate.

Physicians and physician groups specializing in pulmonary diseases and possessing a CLIA or a Compliance and State Clinical Laboratory License, may bill for both the technical and professional components of clinical laboratory tests, provided that the physician and physician group are enrolled in the Medi-Cal program as a Clinical Laboratory provider and are providing services to non-hospital patients.

For additional information, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section in this manual.

This information is reflected on manual replacement page medne pul 5 (Part 2).

Correction: Flow Cytometry Code Update

An article that ran in the July 2006 *Medi-Cal Update* incorrectly stated the following:

CPT-4 codes 88184 and 88145 must be billed with modifier -TC (technical component).

The policy should read:

Codes 88184 and 88185 must be billed with modifier -TC (technical component).

Providers should note that code 88145 is not a Medi-Cal benefit.

The July article was released to announce that effective retroactively for dates of service on or after November 1, 2005, flow cytometry codes, including codes 88184 and 88185, were assigned specific prices.

The full descriptions and maximum reimbursement for codes 88184 and 88185 are repeated below for provider convenience:

CPT-4 Code	Description	Medi-Cal Rate
88184	Flow cytometry cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	$42.18
88185	each additional marker	$20.68

Reminder: No action is required on the part of providers. Claims submitted with these codes for dates of service beyond the six-month billing limit must include delay reason code "11" in Box 31 and include documentation justifying the delay.

Bilateral Radiographic Billing Update

Effective for dates of service on or after October 1, 2006, providers using a unilateral radiographic procedure code to bill for bilateral radiographic procedures must bill with the appropriate CPT-4 code and modifier (-TC, -26 or -ZS), enter a quantity of two units and indicate, either in the *Remarks* area or on an attachment, that the procedure was performed bilaterally. Providers must not use modifiers -RT or -LT, or bill on multiple claim lines. A claim example has been developed to accurately portray bilateral radiographic billing. *The updated information is reflected on manual replacement pages radi 3 (Part 2) and radi bil ub 4 and 5 (Part 2).*

Primary Diagnosis Code Changes for GHPP Claims

Effective September 1, 2006, claims for reimbursement of Genetically Handicapped Persons Program (GHPP) services may be billed with a primary diagnosis code that reflects the condition for which the client seeks medical help. Previously, the primary diagnosis was limited to the ICD-9 code for the condition that qualified the client to participate in the Genetically Handicapped Persons Program.

For example, under the new policy if a client qualifies for GHPP due to cystic fibrosis (ICD-9 code 277.0) but presents to the doctor with the flu (ICD-9 code 487), then the code for the presenting condition would be entered as the primary diagnosis code. The code for cystic fibrosis would be entered as a secondary diagnosis.

This information is reflected on manual replacement pages genetic 5 and 6 (Part 2).

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71	238.72	238.73	238.74
238.75	238.76	238.79	277.30	277.31	277.39	284.01
284.09	284.1	284.2	288.00	288.01	288.02	288.03
288.04	288.09	288.4	288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64	288.65	288.69	289.53
289.83	323.01	323.02	323.41	323.42	323.51	323.52
323.61	323.62	323.63	323.71	323.72	323.81	323.82
331.83	333.71	333.72	333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19	338.21	338.22	338.28
338.29	338.3	338.4	341.20	341.21	341.22	377.43
379.60	379.61	379.62	379.63	389.15	389.16	429.83
478.11	478.19	518.7	519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11	523.30	523.31	523.32
523.33	523.40	523.41	523.42	525.60	525.61	525.62
525.63	525.64	525.65	525.66	525.67	525.69	526.61
526.62	526.63	526.69	528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *	608.23 *	608.24 *	616.81 **
616.89 **	618.84 **	629.29 **	629.81 ** +	629.89 **	649.00 ** +	649.01 ** +
649.02 ** +	649.03 ** +	649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +	649.13 ** +
649.14 ** +	649.20 ** +	649.21 ** +	649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +	649.40 ** +	649.41 ** +	649.42 ** +
649.43 ** +	649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +	649.60 ** +	649.61 ** +
649.62 ** +	649.63 ** +	649.64 ** +	729.71	729.72	729.73	729.79
731.3	768.70 #	770.87 #	770.88 #	775.81 #	775.89 #	779.85 #

Please see **ICD-9 Code Update**, *page 13*

Additions (continued)

780.32	780.96	780.97	784.91	784.99	788.64	788.65
793.91	793.99	795.06 **	795.81	795.82	795.89	958.90
958.91	958.92	958.93	958.99	995.20	995.21	995.22
995.23	995.27	995.29	V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31	V58.32	V72.11	V72.19
V82.71	V82.79	V85.51	V85.52	V85.53	V85.54	V86.0 ** +
V86.1 ** +						

Restrictions

* Restricted to males only
** Restricted to females only
# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

The updated information is reflected on manual replacement pages chemo 22 (Part 2) and inject 27 and 29 (Part 2).

Doxorubicin Dosage and Reimbursement Updates

Effective retroactively to dates of service on or after January 28, 2005, dosage and reimbursement limitations are updated for doxorubicin (HCPCS code X7588).

The dosage for doxorubicin is based on diagnosis and square meter (m^2) of body surface area (BSA). The allowable dosage is 20 mg per m^2, increased up to 40 mg per day for treatment of Kaposi's sarcoma and to 140 mg per day for the treatment of breast or ovarian cancer.

If the dosage exceeds 40 mg for Kaposi's sarcoma, providers must document that the patient's BSA is greater than 2.0 in the *Remarks* area of the claim or on an attachment. If the dosage for ovarian or breast cancer exceeds 140 mg per day, providers must document that the patient's BSA is greater than 2.8.

Code X7588 is reimbursable only when billed with diagnosis codes 174.0 – 175.9 (malignant neoplasm of the breast), 176.0 – 176.9 (Kaposi's sarcoma) or 183.0 – 183.9 (malignant neoplasm of ovary and other uterine adnexa).

The updated information is reflected on manual replacement page chemo 24 (Part 2).

Instructions for Manual Replacement Pages — Part 2

September 2006

Clinics and Hospitals Bulletin 383

Remove and replace:	*Contents for Clinics and Hospitals Billing and Policy* vii/viii *
Remove:	anest 1 thru 18
Insert:	anest 1 thru 24
Remove and replace:	chemo 21 thru 24
	genetic 5/6
	hyst 3/4 *
	inject 27 thru 30
Remove:	medne pul 3/4
Insert:	medne pul 3 thru 5
Remove and replace:	path cyto 1/2
	podi 1 thru 7
	preg early 7/8
	radi 3/4
Remove:	radi bil ub 1 thru 3
Insert:	radi bil ub 1 thru 5
Remove and replace:	radi dia ult 1/2
	surg bil mod 7/8

* Pages updated due to ongoing provider manual revisions.